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Original Lectures.

*THERAPEUTICS OF ACUTE CARDITIS.**

A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, BY A. K. CRAWFORD, M. D., ASSOCIATE PROFESSOR OF THE THEORY AND PRACTICE OF MEDICINE.

LECTURE II.

As intimated at the close of my last lecture there are other measures as well as other remedies important in the treatment of acute carditis, and a chief one which I will now consider is a surgical procedure connected with the pericardium. Having a case of excessive serous effusion in the pericardial sac to deal with, every effort must be directed toward reducing this effusion, else the heart will undergo strangulation. The functions of perspiration and urination must be increased in activity, and the demand thus created for fluid not being supplied by the stomach, the lymphatics of the pericardium may thereby be induced to supply the systemic craving from its temporary reservoir.

Such remedies as digitalis, apis, or pilocarpin, the alkaloid of jaborandi, may bring about this desirable result, or even helleborus may be rightly brought to mind, from its

* Continued from page 109.

therapeutics. Not that it has any special business with this organ and its affections, excepting one, a morbid state with which we have nothing to do at present, but that it has much to do with cases of pyæmia and fevers of the puerperal state, and with Bright's disease and the exanthemata. Under such circumstances I have no objection to the arsenic being prescribed, but if you pin your faith to it and think it will specially help the acute cardiac inflammation which has sprung to life, I am afraid you will be sadly disappointed.

When I was a good deal younger than I am now I once advised arsenicum for a case of post-scarlatinal endocarditis, and I pointed out the symptoms so unerringly that two heads much older and more experienced than mine said "let us try it." They knew then what I have since learned, that such a perfect picture of arsenicum means—death.

Such was the termination of the case and such was the termination of my faith in arsenicum in acute carditis. I would simply urge upon you the necessity of backing up arsenicum, when the latter is called for with a remedy that has a known affinity for the cardiac tissue involved. Besides the general symptoms, always so prominent under this drug, of extreme anguish, nervous restlessness, pallor and debility, you will find the special symptoms leading you to its choice, of palpitation aggravated when the patient lies upon his back, pulse rapid, irregular and even intermittent; a sense of constriction of the chest, which is the fore-runner of cardiac asthma with its train of respiratory difficulties in the forms of dyspnœa orthopnœa and apnœa.

Uræmic hydropericardium, as well as many angina symptoms, are likewise placed under the symptomatology of this drug.

Rather an odd incident is related by Dr. P. P. Wells in regard to spongia as a cardiac remedy. "A woman suffering from organic disease of the heart, ate a piece of sponge just roasted. It had a sudden and alarming effect, produc-

ing terrible palpitation, and a suffocation which threatened to be fatal; the lips became livid, and the respiration violently gasping; there was great pain in the heart, terror, and fear of approaching death. These symptoms gradually subsided after a few minutes; and the attack was followed by a very remarkable relief of the old cardiac symptoms, lasting several weeks."

This is a specimen of a proving which justifies one in placing that remedy among the specific therapeutics of cardiac disease. The action of the drug is undoubtedly and directly exerted upon the heart, and does not simply affect its action functionally and in a reflex way.

A well-marked symptom indicating this remedy is a sudden awakening of the patient after midnight with a sense of suffocation, great alarm and anxiety. Præcordial pain is frequent and well emphasized too, of a stinging and pressing character, oftentimes violent and attended with palpitation. The frequent pulse, both hard and full, points to its use in the early stage of acute inflammation, and the instance cited by Dr. Wells, shows it holds a sway, still, over an old lesion.

Iodium is closely associated in most of our minds with the remedy last discussed, and either may well be kept fresh in mind in cases of cardiac inflammation and exudation because of their powers to bring about absorption. It is a not uncommon belief that because the valve-segments have become thickened and are the seat of exudative vegetation they must remain forever damaged and incompetent to fulfill their function. Such, I am more than satisfied is not the case, and to the power of homœopathic remedies scientifically applied, I rest this belief. Iodium has been urged, in a like sense, in pneumonia and where a croupous exudation co-exists with an acute valvular trouble there would be more than sufficient reasons present for its employment.

Without going over my records, both hospital and private, it seems to me that more of my patients have derived benefit from the administration of lachesis and its

congeners than from any single class or family of drugs. This may be partly due to the fact that the majority of cases are not seen until after they have been running some time, usually nobody knows how long, and only a guess can be made by the physician, as to the start of the disease, on the ground of the patient's story. All the snake venoms act directly upon the heart structures, and therefore there is no reason why any doctor, even though he does not believe in lachesis, for sundry reasons, should abjure this whole class of poisons from his cardiac therapy. There are shades of difference between the indications for naja, crotalus, lachesis, vipera and the rest, but the bulk of the organic constituents of the venoms are, as near as possible, identical.

The general rule I follow is, when a patient, having a cardiac lession of a sub-acute variety, or one having passed the brunt of the onset of the inflammation, presents some symptoms of lachesis, I weigh then the relative intensity of the nervous and sanguineous phenomena. I say the "symptoms of lachesis," because that is the only one of the group of which we possess anything approaching a fully recorded proving.

Now, under lachesis the tendency to disorganization of the blood, and to perturbation of the nervous system are both well marked and pretty evenly balanced; but when the neurotic symptoms prevail naja is the choice, and when the blood changes are most evident, through ecchymoses and hemorrhages, the crotalus is best indicated. Lithium is not very often singled out for a patient with heart disease, but is generally mentioned by authors. The indications given are, "valvular deficiencies, worse from mental agitation, which cause a fluttering and trembling of the heart," and "sudden shocks in the cardiac region." We can hardly stop here to ask how it became known that lithium covered valvular deficiencies, or what sort of a lesion it was which became perceptibly worse from a passing emotion.

I will close this imperfect review of the special therapeutics of acute carditis with a few words on kali. carb. Both from its pathogenesis and its post-mortem records we know positively that it has an affinity for the cardiac structures. Its first-cousin, the chlorate of potash, because of its supposed innocuous properties, is much used by people in an indiscriminate way for "sore throat," and consequently we are called upon when a death occurs in a community to state again how injurious the stuff may be if taken without rhyme or reason.

Of course we homœopaths do not advise our patients to go buy a box of chlorate lozenges for a belladonna sore throat and let them run the risk of poisoning themselves by a surfeit of the potash.

Our kali. carb. is prescribed, and with good effect, in endocarditis, particularly when the mitral valve is the focus of the inflammation, which so readily induces pulmonary stagnation, and thus gives rise to the symptom—"a loud click of the pulmonary artery is heard." But the ever-recurring and characteristic symptom of this remedy is the stitch-like character of the pains. "Stitches about the heart and through to the scapula." And the pulse, unequal, irregular or intermitting, is more rapid in the morning than in the evening.

As to belladonna, veratrum, phosphorous and many more remedies, they must be considered more in the light of adjuvants to the pronounced cardiac remedies, or as intercurrents when special symptoms or conditions outside the heart call for them.

Clinical Society Transactions.

HOWARD N. LYON, M. D., SECRETARY.

NOVEMBER MEETING, 1890.

The regular monthly meeting of the Clinical Society was held in the club-room of the Grand Pacific Hotel, Saturday evening, November 29th, Dr. Isadore Green, Vice-President, in the chair. The session was devoted to hearing and discussing

THE REPORT OF THE BUREAU OF OBSTETRICS.

SHELDON LEAVITT, M. D., CHAIRMAN.

THE PREVENTION OF VULVAR LACERATION DURING LABOR.—BY SHELDON LEAVITT, M. D.—It is a wonderful migration, that of the fœtus from the uterine cavity to the outer world. Those powerful muscular throes of an aroused womb, recurring with clock-like regularity; that expansion of the os from a miniature size to a mammoth opening; that gradual descent of the fœtus along the widening canal, and that final exit at the vulva, marked by unparalleled pain, effort, struggle and final triumph, condense into an experience, which, for surprise, consternation, despair and agony has no parallel. But then the succeeding heaven, the calm after the storm, the stillness after the upheaval, the rest after a wearing warfare with a relentless opponent—but for this labor would be absolutely unendurable. Is it any wonder that during the struggle something gives way? I confess surprise that much integrity of structure is left after such an experience. How to keep the almost inevitable injury within bounds, is a question worthy of more than passing notice.

Owing to the form and direction of the parturient canal, following as it does an irregular curve, the struc-

tures in that part of the curve which is least in accord with the uterine axis, and hence farthest from the line of propulsive energy, receive the brunt of the force, and are compelled to make the chief resistance. The included angle of the two sides represented by the line of pelvic entrance and the vulvar plane upon which the fœtus finally emerges, is practically a right angle, and hence the pelvic floor is obliged to meet the descending head and deflect it in the direction of least resistance, at the expense of considerable strain. It follows that the question of laceration of these structures is very largely determined by their strength and elasticity.

We do not need to make many examinations to learn that there is a vast difference between perinea. Some are large and thick and strong, while others are small and thin and weak. The former can resist a powerful strain, while the latter are capable of withstanding but little. Pass your finger during labor along the vaginal surface of the perinæum and pinch the body between the thumb and finger.

In one case you find it thick and firm, but moderately long as measured from the vulva to the anus, and evidently able to bear, without breaking, all the power which is likely to be applied from above. Again you find a long, thin moderately muscular structure, comparatively yielding, and clearly unable to turn aside a body propelled against it with much force. In a third instance you find almost an entire absence of perinæum, the recto-vaginal septum being but slightly thickened below, so that a shallow laceration would extend to the rectum. In a case like the first we have seen the head press firmly down on the pelvic floor, the perinæum resolutely resisting the strain for a considerable time, and finally turning the descending head aside and causing it to glide forward through the vulva, whence it escaped without harm to the soft structures of this part, the integrity of which is so essential to the health of the generative organs. In cases like the second we have seen the long, thin perinæum yield under much less strain,

splitting to the very margin of the anus. Lastly, in a case like the third, we have seen the deficient parinæum left after delivery still more deficient than ever.

I do not design to show here in detail the effect of laceration of the perinæum under these varying circumstances, on the general tone of the pelvic structures, but I may say that there is a marked difference in the effect of solution of continuity between one perinæum and another, one being better prepared to suffer loss without serious effect than another.

Danger of laceration is much augmented by unusual length of the parturient canal below the bony outlet. During descent of the advancing head the soft tissues are pushed more or less in advance and the greater distance required to be made by the head, and hence the more extensive the curve, the greater the danger to the perinaeum. This truth is to be borne in mind during our consideration of the proper measures to be adopted for protection of the vulvar structures, and above all in our conduct of labor complicated by such a condition.

At the moment of greatest distention, the very margin of the perinæum at the posterior commissure is nearly always thin, and it is evident that a rent once started is liable to become extensive. I am speaking now of cases left substantially to the natural movements. When a rent is begun it draws the head way from the anterior boundaries, or more properly speaking, diminishes the pressure against the crown of the pubic arch, with a resulting extension of the laceration beyond the degree essential to easy escape of the head. This is a natural result of neglect on the part of the accoucheur to enforce the true principles of perineal protection about to be enunciated.

Those who carefully examine the perinæum during the moment of greatest distention have frequently observed that there is usually a thin margin extending backward only a limited distance, and then the examining finger comes upon a thick, firm, strong part, which appears to be the perinæum proper. This thin portion is made up

chiefly of integument and mucous membrane, while the thick part is composed largely of muscular tissue. This is a favorable condition of things to find, but it does not exist in every case, and where it is absent, in a primipara, we ought to be on the alert. When it does exist, laceration, if it takes place at all, is likely to be limited to the anterior thin part of the perinæum, exceptionally extending into the muscular structures. In these cases the thick part of the perineal body serves as a boundary to the tear, casting the pressure back on the pubic arch whence it had begun rapidly to leave.

I am not among those who ascribe vulvar laceration exclusively either to the head or the shoulders, nor am I disposed to unite with some in ascribing the accident more frequently to the shoulders than to the head. Still I am quite willing to admit that the perinæum is often torn during passage of the trunk of the child. Obstetricians are quite accustomed to say that the trunk can follow wherever the head can go, and as a rule, so it can. Yet I have seen the head pass without injury to the perinæum, and a laceration result from pressure of the fœtal elbow as it slipped through the vulva. I am well convinced that more injuries to the perinæum and vestibule occur during passage of the head than of any other part; but next in frequency stand the fœtal elbows. I believe the shoulders themselves rarely cause the accident. When the elbow of the child comes over the distended perinæum, as it often does, with a jerk, the structures which had previously resisted most heroically may finally give away.

The conditions which promote solution of continuity at the vulva are more especially met in the primipara. The intact fourchette, the narrow vagina and the resisting tissues are all of this nature. When once the vulvar orifice has been thoroughly distended, it yields more readily a second time. Moreover, though these structures are decidedly elastic, after thorough distension they never wholly regain their former tenseness. It therefore follows that we look for laceration mainly among women for the first time

in labor. Still it does occasionally happen that the first child is premature, and hence small, while the second is of full term and much larger. Again, a former laceration may have been repaired, and the conditions met in a second or third labor prove as inimical to the perinæum as those in the primipara.

It should be remembered that the vulva may suffer anteriorly as well as posteriorly. As the head emerges from the vulva, the vestibule can be felt with its thin, tense margin turned toward the head, ready to tear should much further strain be put upon it. Since I have made it a custom to search these mucous surfaces for tears after delivery, I have found this region a common seat of injury. A laceration in this part usually passes to one side of the meatus urinarius, and when present is liable to make urination somewhat difficult and occasionally impossible. I believe this to be a more common cause of retention of urine after delivery than reflex spasm excited by lacerated perinæum.

The anatomical conditions being such as we have described, it is plain that rapid descent of the head and sudden pushing asunder of the contiguous structures, with forcible distention of the vulvar opening, are more likely to result in laceration of the parts involved than a dilatory accomplishment of the same parturient act. Here, as elsewhere, haste makes waste. Rapid changes in the human organism are accomplished at unusual risk. Nature's plan is the gradual one. The whole body can be broken down and renewed without pain or disturbance if the work be done by degrees. Cyclonic movements are destructive.

When the perinæum is unusually long and comparatively yielding, it is subject to great danger, no matter whether protective measures be adopted or not. Cases have been put on record wherein the descending head has steadily pressed on its center to such a degree and for so long a time, that finally a false opening has been created through which the fœtus has emerged without rupture of either the posterior vaginal commissure or the sphincter ani. To be sure this is a singular accident, and fortu-

nately rare. There is a form of laceration in such a perinæum, however, worthy of special notice, of which I have recently had two or three marked examples, and which is doubtless of great frequency. It is not discovered through mere touch except in bad examples of it, and does not disclose itself to mere inspection unless the same be carefully made. Externally there may be no sign of injury, but upon retracting the perinæum and opening the labia, we find the lesion in the form of a superficial rent along the vaginal surface of the perinæum, occasioned probably by the head as it pushed heavily along on its way to the vulva. Though of but slight depth, it may be found on lateral traction, to gap more than an inch. Such a laceration is not likely to be felt very profoundly in the way of weakening the natural supports of the pelvic viscera; but it acquires importance by reason of its favorable situation for taking up septic matter during the puerperal condition.

Now all these dangers are still farther augmented by failure of the head in its descent through the pelvis, to maintain its position of firm flexion in vertex presentation, or firm extension in face presentation. When such proper relations of the advancing head to the pelvis are not maintained, the longest diameter of the head, namely, the occipito-mental, is liable to be thrown into one of the pelvic diameters; and since the former is greater than the latter, the head is likely to become incarcerated and instrumental interference be required. Mere use of the forceps does not necessarily increase the perineal dangers, but the delay at that particular point, and final rectification through forcible flexion, followed by instrumental delivery, does militate against perineal integrity. But the head is far more frequently thrown out of proper position to a moderate degree only, in which case though incarceration may not ensue, unusual demands will be made on the pelvic outlet, and the vulva in this way come to suffer. This anomalous condition of things thus becomes a prominent factor in the production of perineal laceration.

These are the main facts relative to causation of peri-

neal rupture, plainly, but not nicely put; and now let us turn to a consideration of the prophylaxis of the accident. The original method of managing the head and shoulders as they passed the pelvic outlet was doubtless the expectant one, and some still adhere to it. "Hands off," they say, "and you will get better results than are obtained when attempts are made at prevention." When manual aid became the practice, it was almost the universal custom to do what is known as "support the perinæum." This treatment was based on right principles, but was probably carried to unnecessary and harmful extremes. At any rate there was a reaction from it, so that now a number of the best obstetricians practice the let-alone method. Reflex action is originated, they say, and the uterus is thereby excited to more energetic contraction, at the very time when modified action is sought. Of this we are not fully convinced; and, while we may not commend the more ancient method, we are fully convinced that, properly used, some form of perineal protection is far better than the expectant plan.

Before we enter upon a discussion of the various methods of protection now in vogue, let us deduce the general principles upon which any form of perineal protection, in order to commend itself to the enlightened judgment of a practical obstetrician, should rest. If we once get a clear conception of these, we will have little trouble in adapting different methods to varying circumstances. The true principles of perineal protection are four in number, as follows:

1. Prevention of too rapid progress of the head and after-coming shoulders.

2. Maintenance of firm flexion of the head in vertex presentation and firm extension in face presentation.

3. Deflection of the head from its movement of direct descent, causing it to hug the pubic arch; and

4. Relaxation of the vulvar structure so that the necessary dilatation may be obtained without too great strain on the soft tissues.

The first may be accomplished by independent manœuvers, such as plain pressure against the head as it is forced downward by recurring uterine action; but it is much better to combine this with such measures as will carry into effect also one or more of the other principles. The necessity for this resistance is at the pelvic outlet only, where there is likewise a demand for practice of the other principles. But better than all resistance is a wise modification of the propulsive energy, which may in a measure be accomplished by directions given the woman herself. Uterine action is not, but abdominal action is, in a measure, voluntary. Under command of the will, abdominal action is often surprisingly powerful. To completely overcome it through an effort of the will is utterly impossible, but much can be done by enjoining voluntary propulsive effort and bidding the woman give vent to her agony in cries, while regularity of breathing should be maintained as far as possible. These measures alone may suffice, but in some cases it is advisable to administer chloroform till the vigor of the contractions is broken and the head is thus brought under control.

There are two, and only two methods of protection for the perinæum at the moment of greatest distension worthy of the name. The first is the old one of pressure against it with the flat of the hand in the direction of the pubic arch, and the second is that originally proposed by Fasbender, in the practice of which the head is grasped by the hand in such a way that the points of pressure are at the poles of the occipito-frontal diameter. To do this either the thumb or the fingers will be passed into the rectum, according as the woman is on her side or her back. All other manual measures are fragmentary and undeserving to be called methods.

"For the purpose of supporting the perinæum," says the old time author Ramsbotham, "we sit rather behind the patient, and apply the palm of the left hand—guarded for the sake of delicacy, cleanliness, and convenience, with a soft napkin—steadily and firmly against the perineal tumor. To give the required protection, it is not necessary

that we should make powerful pressure, or resist the child's exit by the employment of any exertion; we are only to afford a passive support. Placing our elbow on the bedstead, we render it a fixed point, and rather allow the head, covered by the thin structures, to be protruded against our hand, than forcibly press our hand up against the head. This part of the duty of the obstetrical attendant is sometimes exceedingly fatiguing. We may occasionally be compelled to remain many hours by the side of the bed, without moving from our seat. It is not to be wondered at that, under such an irksome posture, the hand should become numbed, and the whole body cramped; but we must put our own personal inconvenience, quite out of the account, when weighed against our patients safety; and we must recollect, that the more rigid the posture—the longer time they take in dilating—the more our assistance is necessary. We must not permit any length of time that we may have been so fatiguingly occupied, to rise as an excuse for relaxing in this duty; but always bear in mind, that if the uterus act strongly, and the head be protruded suddenly, while the parts have not the advantage of the support we can afford, there is great danger that such a degree of laceration may occur, as will perhaps render the woman miserable for the rest of her existence."

The practical mind of Tyler Smith dissented from these extreme views. "Some years ago," he says, "I pointed out that pressure on the perinæum excited reflex contractions of the uterus— a point which is, I believe, now pretty generally recognized; and I grounded upon this circumstance, and upon the facts that, in case where pressure or support is most assiduously rendered, laceration sometimes occurs, while it rarely happens when women are delivered by themselves, an objection to the constant and sustained support of the perinæum during the latter part of labor. I believe that long continued support tends to produce the accident, by increasing the expulsive pains and by damaging the perinæum itself. We read of cases in which the perinæum was supported for hours in succession, which must always be unnecessary, since, if the pains are strong enough to threaten laceration, the expulsive stage could not last the time described."

The precise mode of support as applied by the flat of the hand, with the woman on her side, is thus described by Parvin :

"Supposing the patient to be lying on her left side, and her hips quite near the edge of the bed, the practitioner places his right hand so that the concave palm receives the convexity formed by the bulging perinæum, the thumb is upon the right, and the four fingers upon the left labium majus, while the fold between the thumb and index finger corresponds with the anterior margin of the perinæum, moderate resistance is made to force driving the head against the perineæum, and at the same time the head is gently pressed toward the pubic symphysis; strong pressure is to be avoided, because, if the perinæum be very thin, such pressure at this thinned part may cause a central tear. No napkin should be inter-posed between the hand and the perinæum; the hand is not applied until perineal distention begins, and the application is only during a pain."

When the patient is lying upon the back these details are not observed, but the head is received into the palm of the hand.

This method of treating the perinæum during expulsion of the fœtal head, greatly modified as it has been from the old mode, well applies, three out of four of the principles hereinbefore laid down, namely: Resistance to too rapid advance of the head, maintenance of firm flexion, and elevation of the head well into the pubic arch. What are the objections urged against it? One objection alone, namely that pressure, even intermittingly made against the perinæum, excites the uterus to fury, through reflex action. Distended and benumbed as is the perinæum at such a time, this stricture on the procedure is seen to be most ridiculous. That the latter does save some perinea, either wholly or partly, I am well convinced.

The second method to which allusion has been made, namely that wherein the head is brought under control by being grasped over the poles of its long diameter, has a variety of modifications. The following, described by Hart, embraces three of the general principles which I have laid down:

"All the attendant can do," he says, "apart from the familiar means of relaxing perineal spasm by chloroform

and hot applications, is to prevent the sinciput being forced down in advance of, or faster than the occiput: He restrains the fœtal head from advancing too rapidly. He thus has always to get the occiput to lead, and to get it fully born if possible. So far as I can judge, the best way of doing this is as follows: With the patient lying, of course, upon her left side, the attendant places the thumb of his right hand, guarded by a napkin soaked in hot sublimate, in front of the anus and presses it gently there. The pressure is not in the direction of a line joining his thumb and the pubic arch, but nearly in that of the pelvic outlet. By this, descent of the sinciput in hindered, and that of the occiput is favored. When the latter is beginning to pass under the pubic arch, the fingers of the same hand are placed between it and the apex of the arch, so that when the occiput has cleared the arch the fingers are passed toward the nape of the neck, and the head thus grasped in the hand, the thumb lying over the sagittal suture. This gives one complete command over the head which is now engaging in the diameters between the nape of the neck, and forehead and face, and allows the whole passage with as little tear as possible."

Another variety of the same general method is set forth by Lusk as follows:

"In ordinary cases Hohl's method, recommended by Olshausen, has rendered me excellent service. It consists in applying the support, not to the perinæum, but to the presenting part. To this end the thumb should be applied anteriorly to the occiput, and the index and middle fingers posteriorly upon that portion of the head which lies nearest to the commissure. The unconstrained position of the hand enables the operator to exercise effective pressure in the direction of the vagina, while the posterior fingers favor the rotation of the head under the pubic arch. The patient should at the same time be directed not to hold her breath during the pains, except when they are weak and powerless."

In Fasbender's method the patient is placed upon the left side, and when the head appears in the crowning stage, the index and middle fingers are applied to the occiput, and the thumb is pushed down into the rectum, which always stands open, and the head thus seized by the hand and brought under perfect control.

Through use of these latter methods three of the principles of perineal protection are perfectly applied, and I can but look upon them as excellent methods.

The fourth principle is not an essential part of any method which is peculiarly adapted to the moment of final escape of the head, but is rather preparatory to the final strain. Relaxation of the perinæum may be favored by a variety of expedients, among which the application of warm emollients occupies a prominent place. I have frequently drawn away the perinæum from the fœtal head between pains, and poured into the space thus formed warm oil, with what seemed to me to be good results. Hot fomentations against the perinæum are of utility.

Besides such treatment, when I have special reason to fear rupture, I exercise dilative pressure to the vulva during the latter part of the second stage. This sort of manipulation should be begun before the head gets to pressing hard on the perinæum, as considerable time is required to effect our purpose. The fingers lying in the vagina are pressed with some force in a backward direction during the pains, and in this manner the vulvar opening is gradually expanded so that less time will be demanded when the head shall yet to the outlet. The pressure should at no time be very forcible, lest we inflict unnecessary pain and begin a laceration which later may become extensive. The manipulation should at first be made coincidently with the pains, but later can be continued into the intervals between some of the contractions. The obstetrician who does not observe reasonable antiseptic precautions ought never to undertake this treatment. In fact, he who does not conduct his cases in a thoroughly aseptic manner ought to have none to treat.

I have been repeatedly surprised, in following this plan, to conduct a large head through a small vulva, which at first seemed sure to rupture, without any injury, or with the slightest amount of damage.

A few years ago Dr. Goodell, of Philadelphia, recommended a practice intended to secure greater safety to the

vulvar structures through perineal relaxation, the manipulation being the very reverse of that which I have been describing. When the head is distending the perinæum, it is his plan to mitigate the strain at the posterior commissure by hooking the fingers into the anus and drawing the parts toward the pubic arch. The absurdity of such a recommendation is to my mind self-evident. The head is already pressing too hard upon the perinæum, and our aim should be to guide it forward toward the pubic arch, and finally through it, as rapidly as we safely can. To do so with undue haste would greatly endanger the perinæum. A rent begun at its margin through excessive and rapid pressure, may easily be extended to serious proportions. This, of course, we wish to avoid, but to gain relaxation at the posterior commissure at the expense of strong pressure in what might be called the perineal hollow, is unwise. Far better is it to resist farther advance for a time, and then allow the head to make graduated pressure on the posterior commissure up to the moment of safe distention. Throwing the perineal body under the head, as it advances with each pain, does not serve promptly to prepare a safe exit for the presenting part, and seems to me like poor practice. It is postponing the evil moment without changing its character. Advocates may urge that, by prolonging the pressure on the perinæum we promote softening of the part. This is quite true, but the part which most needs stretching, and that which commands the whole situation, is the posterior commissure, or rather that and the fourchette. The strong muscular part of the perinæum can bear a powerful strain, provided the posterior commissure can be kept intact, or can be preserved till the head has nearly passed. But when, before the moment of greatest distention, the entering wedge is applied in the shape of a torn commissure, the laceration is easily carried into the depth of the perineal body.

Lusk mentions a practice which has given him satisfaction, that is also intended to secure relaxation of these parts. "Between pains," he says, "I have been in the

habit, in cases of rigidity, of alternately drawing the chin downward through the rectum until the head distends the perinæum, and then allowing it to recede. It is astonishing how often apparently the most obstinate resistance can be overcome by the simple repetition of this to-and-fro movement, the parts rapidly becoming soft and distensible. Of course it should be discontinued the moment contraction begins, and care should be taken to effect delivery after uterine action has subsided." This expedient is of some value and worthy of commendation.

By means of the fingers, I have, in a number of instances, practiced expulsion of the head between pains. This can be done in the crowning stage of labor by placing the fingers behind the anus and pressing in the direction of the symphysis pubis; but when no great descent has been attained, that is to say, when the head does not lie in the vulvar opening, proper pressure cannot be exerted without introduction of the fingers into the rectum. Such manipulation demands the greatest care, as rough handling might injure the recto-vaginal septum. I sometimes watch descent during a pain, with the fingers in the rectum, and as the contraction dies out and recession of the head begins, I hold it forcibly against the vulvar opening. It is only after repeated attempts that expulsion can be effected. The chief advantage derivable from this mode of delivery is found in the avoidance of the on-rush of propulsive energy, and the encounter of less resistance from muscular rigidity. An attentive obstetrician cannot fail to notice with what force the muscles contributing to the formation of the pelvic floor contract during the recurrent parturient efforts, while in the intervals they remain comparatively quiet. I need not add that this mode of delivery is adapted only to cases wherein there is considerable interval between pains.

This paper would be incomplete without reference to the surgical procedure known as "episiotomy." I have elsewhere given the details of this operation, and I shall not recite them here. It is suited only to certain cases in which serious laceration appears to be inevitable, despite all

other expedients and adjuvants. The instances in which the aid of this operation should be invoked are fortunately rare. By thorough application of the principles herein set forth, serious laceration may nearly always be prevented, and therefore little occasion be given for episiotomy. It is peculiarly adapted to those cases in which rapid delivery seems imperative, and by its use we may be able to afford the woman some protection.

In what I have thus far said especial reference has been made to labor which arrives at its termination without resort being had to instrumental interference. When it becomes necessary or advisable to use the obstetric forceps, protection of the vulvar structures involves the same principles which have been enunciated, but besides them there are special considerations entering into the case. By means of the forceps we can easily enforce firm flexion of the head, we can keep it well up in the pubic arch and we can prevent too rapid exit. The forceps themselves take up so little room, and the compression which they exert so diminishes the involved diameters, that we may truthfully say they do not at all increase the demands on the pelvis, nor by their presence enhance the danger of vulvar laceration. Nor do I state a paradox when I say that these same forceps are sometimes the occasion of perineal and vestibular laceration. Apart from the considerations mentioned in connection with non-instrumental delivery, there is here, I believe, only one important factor in perineal protection demanding special attention, and that is, in some cases, removal of the instrument before delivery of the head. In one case it is advisable to remove the forceps, and in another it is better to keep them on, our action being determined altogether by the manner in which the head is embraced. When the instrument has been applied by the cephalic mode, *i. e.* when the blades lie on the sides of the head, and the pelvic curve of the blade is addressed to the occiput, it is not only not necessary to remove them, but, in general, it is advisable to let them remain. On the contrary, when the instrument has been applied by the pelvic

mode, *i. e.* when the head is held over the poles of either its long or its oblique diameter, the forceps ought always to be removed before the head passes the vulva. The occasion for this difference in practice is found in the presence of the blades in one case, at the moment of delivery, directly in the sides of the pelvis, while in the other, one blade lies anteriorly, in the pubic arch, and the other posteriorly, on the perinæum, thus greatly endangering these structures. It remains to be said, that, when the instrument is removed prior to escape of the head, delivery may be finished by lifting the part through the vulva in the manner before described.

There is some danger of laceration attending delivery of the shoulders, but the only prevention lies in the exercise of care, drawing the body well forward and keeping the elbow off the perinæum, where it is so liable to tear the vulvar commissure.

Discussion. Dr. G. F. Shears.— In my own practice I usually adopt some of the plans suggested. After I got rid of the conventional ideas that I learned in college, I went to the other extreme for a time, and gave the patients a rest. Now I adopt that method which seems best adapted to the particular case.

I am very careful in my examinations and make them only with antiseptic precautions. I am accustomed to wash my hands in a bichloride solution before passing the finger.

In one case of vulvar laceration that came under my notice I am certain that it did not occur until after the head had passed.

If necessary, I support the perinæum. If the parts are dry I use warm oil and annoint the head as it recedes.

I do not believe in frequent examinations ; considering it better to wait after the diagnosis is once established.

Dr. E. S. Bailey : Coming in late I did not hear the first part of the paper, but there are two points of which I will speak. The first is the injury to the perinæum through a

too rapid descent of the child's head. Sometimes the birth is so rapid that the child has come into the world before the arrival of the accoucheur. Again it may come after only three or four expulsive pains. These pains are of the worst kind and a single one may be sufficient to cause a laceration.

The second point is in regard to prolonged labor when the pains are excessively hard. In these cases perinæal support does much to alleviate the sufferings of the woman. In such cases I have resorted to all the expedients that I ever heard of.

I am a firm believer in the use of pure lard as being preferable to most of the agents employed. Vaseline also answers well. There is no harm from the employment of proper lubricants.

Dr. L. D. Rogers: I am inclined to consider that the head, the shoulders and the elbows are all concerned in lacerations, and that the latter are more frequently the cause than we realize.

If the woman is on her back we have the weight of the child in addition to the force exerted by the muscles. In cases of severe labor I am in the habit of placing the patient on her left side. Support can then be readily applied to the perinæum if necessary. As the head reaches the vulvar opening it is my custom to "*unbutton*" it.

Theoretically lanolin should be an excellent lubricant.

At times I have found it absolutely necessary to support the perinæum.

Mrs. Dr. W. P. MacCracken: I was unfortunate enough to have a laceration of the perinæum occur in a patient under my care. I am sure that in that instance it was not caused by the passage of the head.

Dr. W. M. W. Davison: I have always found that in difficult cases of labor, much good results from a liberal use of sweet oil, lard, or some similar lubricant.

I had a case of lacerated perinæum recently in a large primipara. I had expected such an occurrence from the start.

I have often used with good results a method I first saw employed by Dr. W. P. Roberts at the Hahnemann hospital a good many years ago. This consists of applying a towel wrung out of hot calendula water to the perinæum and then making pressure with the hand.

Laceration of the perinæum is bound to occur occasionally, and I do not suppose there is a practitioner of ten years' experience who has not had such cases.

Dr. W. A. SMITH: We all learn from experience that actual practice is not text-book work. I get my best results from not supporting the perinæum, but by giving careful attention to the presenting part.

In those cases of continuous pain described by Dr. Bailey, I have had bad results. At such times I have stood with my heart in my mouth, and the child came any way. It is my practice to ease the strain on the perinæum by lifting the head against the pubic arch.

When I first came from college the teaching was to support the perinæum. About that time it was advised by Dr. Walker to use a book or a folded newspaper for that purpose.

It is from such papers as this that we learn all the little things; how to be neat, and how to make catnip-tea for example. Such things are not in the text-books. I have Dr. Leavitt's book, but would rather have this paper of his.

LABOR WITH EXTRAORDINARY EXEMPTION FROM INJURY. BY DR. O. O. HOCKETT.—Dr. Bailey read the following case as an extract from a letter received from Dr. Hockett:

Case.—I was called to see a lady in labor. I found it to be a primipara. The lady, a farmer's wife, I was told, had been doing duty in the field, gathering corn until two o'clock of the afternoon of her labor and that she had outstripped all the hired men in the work. The child was born at seven P. M. On examination I found it had a spina bifida with a tumor in the lower lumbar region about the size of a small egg. As a fit ending for the case the lady prepared dinner for the household on the second day after her confinement in the face of strict orders to be quiet.

MENSTRUATION DURING PREGNANCY. BY E. S. BAILEY, M. D. *Case.*—April 8, visited Mrs. G. for the first time. Pregnancy was suspected. Menstruation has always been irregular, but patient missed this period for the first known time. Nausea and vomiting was severely persistent for four months, somewhat better the fifth and sixth months. This patient was delivered of a healthy child at the period of seven months gestation Oct. 28th. The infant was very small, and the labor was normal.

The peculiarity in this case being that although the patient failed to menstruate the week of April 18, she menstruated regularly thereafter each month, the flow each time lasted over four days, and was scanty and the pain attending it was like her usual pain at the period being a very severe dysmenorrhœa compelling her to remain in bed during the time. The patient did not menstruate in October, but the symptoms as though the menses would come on were present from Oct. 20th, growing more and more severe until they terminated in true labor pain, Oct. 28.

I know it is reported that pregnant women sometimes menstruate regularly, but my experience is limited to three cases that I now can recall, and this is the first one to have a true dysmenorrhœa during gestation.

DISCUSSION.—DR. G. F. SHEARS: The first case mentioned by Dr. Bailey is very rare, and it would not be safe to advise a similar course for our patients. Many women who practice such a procedure show the effects after several labors.

In regard to the second my observation has been very limited. They are very unusual. I know of none now in which the woman had the same regularity and pain as normally. I should make a distinction between a *showing* at the month and the menses.

MRS. DR. W. P. MACCRACKEN: The child should be considered before the mother; she is of the passing generation while the possibilities of the child are unlimited.

DR. S. LEAVITT: It is not remarkable that a woman feels like getting out of bed the day after delivery. Many would do so if permitted. I believe that this very same woman would show symptoms if closely examined. I believe also that when a woman menstruates during pregnancy the

menses differ from the normal. The flow may last several days, but it is not identical with the normal discharge.

Dr. L. D. Rogers: It would be interesting to know the condition of the first woman after a few years. Two of the worst cases I ever saw gave a history similar to hers.

In regard to Dr. MacCracken's remarks I believe the child suffered from the effects of the mother's overwork. As to the after effects, they are vastly worse from abortion than from getting up too soon after confinement.

In a case of procidentia under my observation the patient was a common field-hand, adopting this work in preference to an in-door life. This case was very severe when I saw it in the spring yet, although she worked hard all summer in the fields, she was greatly improved in the fall.

Dr. E. S. Bailey: As to the regularity of the menses in the last case, I did not know the patient prior to the first month. Then, instead of the flow there was excessive pain, after that the menses became regular, while before she became pregnant they were irregular. She suffered from dysmenorrhœa during the seven months in which she carried her child, and was not aware of her condition until four hours before the birth of her baby.

The child was born at the seventh month and is now alive and well.

Volunteer Papers: 1. Plastic surgery in the treatment of deformities of the face. By Dr. G. F. Shears.—In no department of surgery is greater ingenuity of conception or more pains-taking care in execution demanded than in the treatment of deformities of the face. No two deformities are exactly alike with regard to character, location and organs involved, and as no rule can be laid down which can be explicitly followed, each operation must be largely experimental. Again a result which, in other portions of the body might be considered excellent, may in the face be only an added distortion.

These operations in most cases are not necessary to

prolong life or to relieve physical pain,but simply to improve the beauty of this most exposed portion of the body. The person afflicted often has no reasonable idea of the limitation of the art of surgery, and forms his expectations not so much upon the stock that he has in trade as upon the ideal of beauty that he desires to attain. The most praiseworthy results are therefore often met with little or no appreciation.

The following are some of the more interesting cases which have presented themselves to me during the past two years :

Case 1. Congenital large lower lip.—B. S. H.—aged 19 —From Dr. F. B. Stiles, Sparta, Wis.—This patient had a congenital enlargement of the capillaries of the entire left side of the face producing a marked strawberry discoloration. The entire lower lip was not only discolored but markedly hypertrophied, being fully one inch greater in length and one-half inch thicker that the upper lip. When the mouth was closed it projected noticeably beyond the upper lip and lay in a little fold on each side of the commissure of the mouth. Upon the mucous membrane to the left of the commissure was an ulcer the size of a ten cent piece. The exposed portion of the mucous membrane which could not be covered by the upper lip, was very sensitive and became sore upon exposure to cold or dust so that the patient ws unable to work out of doors except in pleasant weather.

The operation to remedy this defect consisted first in the shortening of the lip, and secondly, in the reduction of its thickness.

As the enlargment was greatest upon the left side, and in order to do away with the ulcerated surface a V-shaped piece was removed a little to the left of the median line. The base of the V was one inch in length and the apex reached below the chin. The edges of the external wound were brought together and held by hair-lip pins and figure of eight sutures. The vermilion border of the lip and the mucous membrane were brought together with cat-gut sutures. Two weeks later the wound was thoroughly healed and the second step in the operation was undertaken. In order to reduce the thickness of the lip two incisions 4-8 of an inch apart at the widest point were

made extending from one commissure of the mouth to the other and a wedge-shaped piece removed. The result was all that could be desired so far as the form of the lip was concerned. The line of incision through the mucous membrane, however, remained very sensitive. Thuja tincture was applied and the sensitiveness almost entirely disappeared and the patient was allowed to go to his home. Four months later he returned with a thick crust covering the line of incision through the mucous membrane. He had had malarial fever and during his illness this crust had commenced to form. No one had dared to remove it, believing, as he said, that it was of a cancerous nature. The crust was removed and a slight ulcerated surface was found underneath.

Local application of fluid extract of ergot was made and in a short time the parts were healed. He was not under Dr. Stiles' care.

Case 2. Congenital large nose. Frank M ——, aged 23 years. Referred to me by C. G. Fellows, M. D., of this city. This young man complained of the excessive size of the lower portion of his nose, which at the alæ broadened out, giving a flat duck-billed appearance to that organ.

The shape, while not such as might be called a deformity, was certainly not an ideal one. Inasmuch, however, as it performed all the functions of a nose satisfactorily, he was advised that an operation was unnecessary. He replied that he had good reasons which decided him in determining to have the operation if the shape of the nose could be improved. Acceding to his demands therefore an eliptical-shaped piece 1¼ inch long by ⅜ inch wide was removed from the dorsum of the nose, the incision beginning at about the nasal bones and terminating at the apex of the nose, dividing all the tissues the cartilage included but not cutting through the mucuous membrane.

The edges were brought together by fine silk sutures which were imbedded passing through all the tissues and bringing the deep surfaces of the wound together. The sutures were removed in 48 hours and pressure kept up by means of adhesive straps. The wound healed nicely leaving an almost imperceptible scar. The shape of the nose was very much improved and the entire expression of the face seemed changed for the better. The patient departed entirely satisfied with the results.

I have never in my practice or in my reading met with

a similar case, and I may therefore have ventured upon virgin soil, but I deem it not improbable that others have performed the same operation without reporting it, as happened in a case which I shall report further on.

Case 3. Removal of a scar from the cheek—Lilly G.—aged 10 years, has an irregular semicircular scar upon the left check,the result of a lacerated wound received two years ago. At that time the little patient fell upon a stove pipe and much of the soot with which the pipe was covered was pressed into the wound. The physician in attendance was either unable or did not attempt to cleanse the wound, for much of the soot lies imbedded in the cicatrix making it almost black. The cicatrix was dissected out, the utmost care being taken to make the incisions clean cut. The parts were brought together with carbolized silk and perfect union took place. The stitches were removed in 48 hours, the wound being supported by adhesive plaster. Six months after the line of incision could only be detected by the closest scrutiny.

Case 4. Congenital malformation of the left ear.—Stella H.—aged 27 months, was sent to me April 8th, '89, by Dr. Green.

In this case the right ear was of normal size and shape, but the left ear was very prominent. The antihelix being absent and the fossæ of the helix, antihelix and concha forming one cavity. An oval incision about one inch long and 3-8 in. wide, nearly on a line with the natural depression of a normal ear, was made on the posterior surface of the auricle and the skin removed. A V-shaped piece with the apex of the V anteriorally was removed from the cartilage without injury to the integument of the anterior surface. The cartilage was stitched together with cat-gut and the integument with carbolized silk. The ear was bandaged to the head. The stitches were removed on the fifth day, but the bandage was retained for one week.

The result was all that could be desired. At the time of the operation I did not know whether a similar one had or had not been previously made. The matter passed out of my mind until almost one year later, when in the Annals of Surgery for January, 1890, I read under the heading, "A new method of operating for relief of the deformity from prominent ears," the description of an operation made by Wm. W. Keene, M. D., which was almost identical in procedure with the one described in this

paper. In this article he says, "When I decided to operate I was not aware that anyone had preceded me in this matter, but I have since found in the Archives of Otology, N. Y., 1881, Vol. 10, page 97, a description of a case by the late Dr. E. T. Ely, in which he successfully remedied a similar deformity. Ely removed an oval piece comprising nearly the entire length of the auricle and through its entire thickness, thus including the skin on the anterior surface."

Dr. Keene prefers his own plan, which is identical with mine, giving as his only reason that it leaves no scar in front. While equally desirous that there should be no scar in front to mar the appearance of the ear I was chiefly influenced in my mode of operating by the belief that the shortening of the integument on the posterior surface without infringement upon the anterior integument would naturally draw the ear back. The removal of a piece on the anterior surface would antagonize this result.

Case 5—Cicatricial contraction of the mouth, extending to the angle. Miss B——— age 33 years. Suffered for many years with an eruption of an eczematous character upon the face. As the result the face is scarred and the mouth contracted to fully one-half of its natural size. The mouth has twice been enlarged by simple incision at the commissures. The raw surfaces being left in contact they readily healed and the mouth was left as small as before. The patient now suffers from carious teeth, which the dentist is unable to reach on account of the smallness of the aperture. An operation recommended by G. Buck, M. D., was undertaken. Upon the left side an incision was made along the line of the muco-cutaneous juncture, circumscribing the angle of the mouth and extending an equal distance upon the upper and lower lips, dividing only the skin. An incision upon the line of the commissure of the mouth was made through the skin only toward the cheek and extending as far as the new angle of the mouth. The skin was now dissected up from the mucous membrane and the mucous membrane divided on the same line but not as far out as the incision of the skin. The angle of the skin at the termination of the incision of the mucous membrane was now turned out and attached to the corresponding angle of the skin. The edges of the skin and mucous membrane were then attached above and below, the edges of the skin being trimmed off a little in order to allow the mucous membrane to be everted, so as

to form a vermillion border to the lip. A similar operation was made upon the opposite side. The result upon the right side was perfect, but upon the left side some of the stitches at the angle of the mouth sloughed out leaving the raw surfaces opposed for a short distance. These surfaces healed, making the mouth a little shorter on the left side than on the right. The patient was so well satisfied with the size and usefulness of the mouth that she refused to have this defect remedied.

2. Otic diseases consequent on *la grippe*. By C. Gurnee Fellows, M. D., of Chicago.—Since the epidemic of *la grippe* during the winter of 1889 and '90 there have been a great many persistent and annoying diseases, which have been directly traceable to that epidemic or to the causes which produced it.

In the realm of otology these diseases have not taken especially new forms, but have arisen often without apparent cause, have been unusually persistent, and have required extra patience in treating them.

These diseases have been both acute and chronic, including the suppurative and non-suppurative forms.

The acute troubles are easily amenable to treatment, and although painful, are often of short duration; whereas the chronic troubles, though less painful, are possibly more annoying by their persistence and consequences.

I will give a few types of the different diseases as illustrations:

Case 1. April 30, 1890. Annie ., æt 15, presented herself about a month after an attack of *la grippe*, suffering from functional deafness in both ears, having had no previous aural trouble. The difficulty in hearing was progressive from the time of the attack of *la grippe*, and when examined her hearing distance was 4-36 inches in both ears.

The bone conduction, as tested by the tuning fork, was best. This latter diagnostic point obtains in this case as a result of the inflammation in the middle ear.

Upon inspection, both drum membranes were found to be fairly normal in color, but somewhat depressed. A catarrhal state of the nose, throat and Eustachian tubes

was coexistent. Her disease was sub-acute catarrh of the middle ears.

If left to itself the probabilities are that the hearing would continue to decrease as a result of permanent pathological changes.

In no case is it more true than in middle ear diseases, that if taken in the beginning so much more can be done than after delay.

Treatment. Inflation by Politzer's air bag, according to the usual method; simple alkaline and disinfecting sprays for the nose and throat, repeated every other day produced immediate good effects.

As in all such cases improvement may be more marked immediately after treatment than on the following day. The treatment must be continued until the effect is permanent. One month was sufficient in this case to completely restore the power of hearing, and it remained perfect, upon examination after the lapse of over six months.

Case 2. Mr. S., æt. 60, suffered with *la grippe* one year ago, and consulted me in October, on account of an uncomfortable feeling and deafness in both ears, but more especially in the right ear. He has had repeated attacks of acute nasal catarrh, all of which have increased in frequency and severity since his attack of the *grippe* last winter.

Both ears showed a chronic catarrhal inflammation and the right one had every appearance of becoming acutely inflamed.

The hearing distance for the R. E. was c-36 and that of the L. E. 6-36.

The patient was inclined to be annoyed at the unfavorable prognosis. But in two days it was verified by the oncoming of the terrible pain and the unmistakable evidences of acute inflammation of the right middle ear. The hearing distance had decreased to zero for the watch and on inspection the drum membrane was found to be inflamed and the tympanic cavity filled with serous exudation.

The operation of paracentesis was proposed, but the patient refused to submit to it. Continued applications of hot water for twelve hours produced a perforation in the drum membrane and the suppurative inflammation in the middle ear was fully established.

It is far better, under such circumstances, to incise the drum membrane, as the suffering is lessened, the length of suppuration shortened, and the after results are apt to be more satisfactory.

In the case of Mr. S. suppuration continued for about a week. In a month's time, under appropriate treatment, the hearing distance of the R. E. is $\frac{5}{20}$ and of the L. E. $\frac{3}{4}$ and will continue to improve.

The treatment for the suppurative stage was syringing with carbolized water and dusting with iodoform and boracic acid, white arsenicum was given internally because of constitutional debility.

Case 3, Oct. 15, 1890, Mrs. C., æt. 40. Had had suppuration of the ear in early years, with partial loss of hearing in one ear, but for twenty years it had been quiescent until she suffered from *la grippe* in the winter of 1889 and '90, when a recurrence of the suppuration ensued.

The internal administration of arsenic and the local use of boracic acid have already produced a beneficial effect upon the suppuration. But the prognosis for the hearing is unfavorable.

Case 4. Kate M., æt. 22, has suffered with suppuration of the right middle ear, consequent on an attack of the *grippe* a year ago. The treatment is similar to that used in Case 3, but the prognosis is better on account of her age, and it being her first aural trouble.

We have here examples of the suppurative and non-suppurative types of the disease, and different degrees of inflammation in the supurative form. Success in treating them is fair; as so many others have said, in reference to other diseases following *la grippe*. So also is it true of aural diseases, that they are particularly persistent and less easily cured than those arising from the more common causes.

Ordinarily the local treatment of such cases would accomplish a cure by itself, but it is often materially aided by internal and constitutional treatment. This was especially true of cases consequent upon last winter's epidemic.

Because of frequent relapses, there has not been the usual assurance in pronouncing a case cured.

3. A RARE CASE FOR DIAGNOSIS. (With specimens.) By RHODA PIKE, M. D., of Irving Park, Ill.—Mrs. P., a small brunette, aged 32, married 12 years, has borne five children and had repeated miscarriages. I saw her on various occasions from October to December, 1889, for sick headaches, when she said she had not menstruated for two or three months and thought she might be pregnant, although it had not been unusual for her to "miss" a period. The latter part of December I was called in haste and found her having copious hemorrhage from the bowels, which I think came from the rectum only, as there was but little fæcal matter mixed with the blood. She had, during January of 1890, another hemorrhage from the bowels and one from the stomach. Following the second hemorrhage, she told me, that for nearly a year there had been great vaginal and abdominal tenderness, which had increased until the slightest misstep or pressure downward on the abdomen was torture; that the only way she was able to keep about was by using hot injections and sitz-baths, and that of late, when introducing the syringe-nozzle, she had to be very careful, as she had fainted once or twice from a light touch upon some sensitive spot in the vagina. This she had not told before to any physician, as she knew an examination would be necessary. She did, however, permit an examination, first anæsthetizing the parts with a cocaine tampon, which the patient introduced herself.

This examination and one a few days later with a former physician, when she was completely anæsthetized, revealed an elongated, pointed cervix, reaching nearly to the vulvar orifice, an os so small that the smallest rubber bougie could not be introduced, and spots of inflammation upon the cervix and the vaginal vault that looked almost erysipelatous. All the tissues had that tense, hard feel which belongs to inflamed surfaces.

For a few days following this the patient was instructed to use hot arnica injections and was given the same remedy internally. As soon as the soreness was sufficiently reduced to allow, she went under daily local treatment. This consisted in packing the vaginal vault firmly and nearly the length of the cervix with absorbent cotton saturated with different medicaments, as arnica, hamamelis or hydrastus.

This *seemed* to do a great deal of good for her; the cervix shortened, the inflammation disappeared, the os was slightly larger, the soreness was entirely gone.

In March there was a slight show of blood from the uterus, preceded by considerable bloating of the abdomen. The flow lasted but a day after which she complained of a peculiar gurgling in the uterine region. This gurgling the patient described as a feeling as of liquid running from one cavity to another through a small passage, like the sand in an hour-glass, running from the upper part of the left inguinal into the hypogastric region, and back, according to the position of the body. A week later she was taken with severe expulsive pains, which lasted about an hour, when there was a feeling like the rupture of the membranes during labor and she lost nearly a pint of dark bloody water which looked and smelled like the dregs of a wine barrel. Floating in it were pieces of mucus as large as a hazel-nut. Following this she passed with extreme pains, strips of membrane almost exactly like the lining of an egg-shell, which she pulled away with the fingers, as the pains drove the os-uteri quite down to the vulva.

This condition of things repeated itself the next month, after which she seemed to gain both in health and spirits, the menses were free and regular, and the patient thought she felt better than for years. But the summer season opened with all its demands upon the hospitable home, and she quit treatment entirely, being "too busy" to wait upon anything pertaining to her own well-being.

The middle of September I met the patient casually, and she told me that she had been bloating for a couple of months, that the menses had been scant and that the old gurgling had returned.

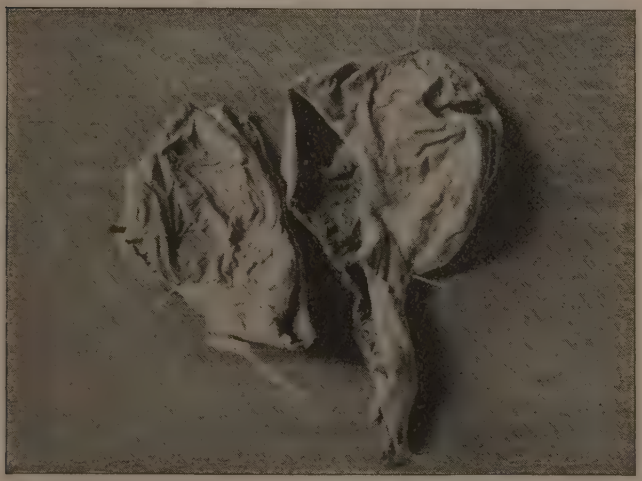
The night of September 28 I was again summoned in haste. She had slight pains for two days, and that night while turning in bed something seemed to give way and the bed was saturated with water. Directly the pains began coming every five minutes and increasing until they were agonizing beyond description. I found the same elongated cervix and narrow os-uteri. The pains were horrible, but I could make no impression upon that contracted outlet. After a time I could feel the internal os yield under the fingers, and each pain shortened the cervix till it lay like a smooth surface under the touch. Two or three very severe pains drove *this* through, and into my hand, as you will see, a uterine cast, but thick and tough enough for a bladder. I supposed the patient's suffering was over, for the month at least, and, for a half hour she was comparatively free from pain, when, just as the womb had begun

to feel and be sore from its former effort, they began again. This relapse was worse than the first attack, caused her to be very delirious, and finally resulted in the discharge of this second specimen. Under the use of arnica and other appropriate remedies she made a good recovery.

I have brought the report of this case desiring information. What conditions could produce such a membrane? Where did that second cast come from? Has my patient two uterine cavities? And what shall I do to prevent a recurrence?

4. Report of the examination of the specimen submitted with the foregoing paper at the October meeting. By Howard N. Lyon, M. D., Microscopist.

A microscopical examination of the specimen submitted by Dr. Rhoda Pike, at the October meeting of the Clinical Society, shows it to be, beyond question, of uterine origin.



When received by me the cast was in two pieces similar in size and shape, except that the small end of one was prolonged, forming a neck-like appendage.

Both pieces were open on one side as shown in the accompanying photograph. On comparing the torn edges

it was found that they joined exactly, and did not as was suggested at the meeting, fit one over the other.

When the pieces are fitted together the cast is heart-shaped, denoting a bifid uterus. (See the accompanying cut.)

From the microscopic appearance of the cast it was apparently formed from the sub-mucous layer of the uterine lining, the epithelial layer having disappeared at some previous time from endometritis or some similar cause, most likely from the severe intra-uterine treatment that the patient had received in New York before coming under Dr. Pikes's care.

5. Clinical observations based on over four hundred abdominal sections. By Dr. R. Ludlam.*—6. *The incision.*—On receiving copies of the first edition of Peaslee's and of Atlee's works on ovarian tumors and ovariotomy in 1872, one of the subjects that most interested me was what they had to say of the proper length for the abdominal incision; for there had already been a great deal of discussion of this matter, and ovariotomists were ranged into two camps, those who always laid open the abdomen from the sternum to the symphysis pubis, and those who made as short an incision as possible for the extraction of the tumor, as Dr. Nathan Smith did in 1821. As usual, in so far as they applied either method to all cases indiscriminately, both parties were in the wrong and a deal of mischief had resulted.

Since that time we have learned why an unvarying course in either of these respects is beset with danger to the patient. The old surgical idea that a free cut was necessary because it allowed "every part of the operation to be done by sight" often exposed the abdominal contents unnecessarily, and sometimes resulted in rupture of the cyst or cysts, an accident which added the risk of sepsis to those of chill and of shock. Without being savage in my surgical proclivities, I was an advocate for the long incision until 1874, when I exposed a large monocyst, which undoubtedly was parovarian, through an incision that was about nine inches in length. This opened my eyes to the wrong of it, and, although my patient recovered, she had to

* Continued from page 510.

pass through the so-called "suppurative period" of those days with a wound that need not have been larger than a big button-hole.

In the case of solid and composite tumors, as well as of multilocular cysts of the ovary, the section should be so free as to admit of the extraction of the growth without straining the wound or bursting the sacs, and so emptying their contents into the abdomen. Nothing is gained and a great deal may be lost by the opposite course. For this reason in the removal of large uterine fibroids, of condensed cysts, and of the uterus in supra-vaginal hysterectomy, the incision should be long enough to enable us to work easily and not to be embarrassed by having to force the growth through too small a wound.

If it was still necessary that every part of the operation should be "done by sight" the removal of the uterine appendages, as in the Battey-Tait operation, would now be almost as fatal as ovariotomy used to be; and we would not be warranted in taking any such risks for the relief and the radical cure of the various forms of salpingitis, recurrent peritonitis, and even of the apochryphal cellulitis and abscess, as is being done every day by those of us who, while we sometimes work in the dark, are privileged to walk in the light.

Besides, since the exploratory incision has been legitimized, we have the option of beginning with a small opening and ending, if necessary, with a large one.

Concerning the length of the incision, therefore, my experience has brought me to favor the long one for large and solid, or semi-solid and irreducible growths; and the medium or the short one for such tumors as are small, monocystic, tubal, and for a majority of those which are parovarian, intra-pelvic and intra-ligamentous. Where one is in doubt it is better to make a small opening first, and if need be to enlarge it afterward. If the abdominal wall is very thin because of its distention and of a general emaciation, access to the tumor is so easy that the cut does not require to be so long as where the parietes are thick and there is a great deal of adipose tissue.

I have learned that there is increased safety in making the incision of the same length through all the layers of tissue, the integument and the peritoneum included. And I am fully convinced that the old way of slashing through these textures, as the army surgeons used to cut to the bone with their first stroke in amputating a leg or an arm, is to be

deprecated most decidedly. By avoiding this meretricious and mischievous practice I am happy to say that, although I have often cut down upon them, I have never yet injured the bladder or the intestines in the slightest degree.

It is my firm conviction that the old method of reducing the size of a multilocular tumor of the ovary by first emptying one cyst and then breaking through the partition walls so as to empty others through it, was, and is likely to be a fertile source of sepsis whenever it is practiced. It is much safer after having tapped the parent cyst and closed its mouth with a trusty pair of lock-forceps, to enlarge the abdominal incision and take it out whole. Even if the cyst-wall is rotten, this is the better way: for, where there is danger of rupture we can turn the patient, tumor and all, upon her side and let the vicious contents run over the table and not into the abdomen.

My practice has been to hasten slowly in gaining access to the peritoneal cavity, because by so doing there is less danger of wounding the underlying organs, and because the hæmorrhage can be arrested as we proceed, and a consequent sepsis averted. In filling the last of these indications nothing has given me such satisfaction as the application of hot sponges and sponge-pressure to the sub-cutaneous tissues before cutting through them. Where the structures are not venous this expedient is a sort of Esmarch's bandage, that reduces the loss of blood to the minimum, and in many cases even does away with the need of the catch-forceps. Only those of us who were once obliged to seize the little vessels singly with the stupid old forceps, and to stop the bleeding by ligature or torsion, before the days of hæmostasis by hot water, can fully appreciate the advantages of this simple method.

In this way it is not so very important that the central, or usual incision, should be made through the linea alba; and where we have to reopen the abdomen in a second operation, or in cutting for the cure of a ventral hernia, this is no small advantage.

In five of my cases the abdomen was so very large and the consequent pressure of the tumor so great that the patient could not lie upon her back. Under the circumstances it was not safe to administer the anæsthetic either in the usual way or in the sitting posture. The patient was therefore placed as carefully as possible upon her side, and partially anæsthetized, a small incision was hastily made, the cyst tapped and the mouth of it dragged out and

secured, so that none of its contents could escape. After this double precaution, she was turned upon her back and the operation finished in the usual way. This plan I have found to be much safer than to tap the cyst through the abdominal parietes some hours or days before its extirpation, as Kœberle and other continental surgeons used to do. Although four of these five cases had carried the tumor through more than six years each, and one of them for twenty-eight years, they all recovered.

In making the abdominal incision in certain cases there are two conditions which, like the red light in a druggist's window, signify danger. One of these is an extraordinary tendency to venous oozing and hemorrhage, and the other is a dropsical condition of the parietes, in which a flow of water follows the knife. This hemorrhagic tendency is, in my experience at least, a pretty certain sign of malignancy in the tumor. I am not speaking of the occurrence of hemorrhage from the large veins which can be seen and avoided, or pinched on either side of the line of incision with a Péan's forceps before being cut, but of the bleeding that is general throughout the wound and which does not promptly respond to the action of the hot water, or if it ceases for a little, comes again and continues until the wound is finally closed.

The abdominal anasarca may be due to the long-continued pressure of a large fibroma, or of an unusually large tumor of any kind. If it is not attended by renal embarrassment with albuminuria and scanty urination, or confirmed Bright's disease through pressure upon the renal vessels and the ureters, it still may be a sign of very low vitality and of great exhaustion. Such symptoms are not necessarily mortal, for some of these patients do finally recover, but I have come to regard them as very suspicious and suggestive.

In some of the smaller tumors that occupy the lower part of the abdomen and the pelvis, as well as in making an operation for the removal of the uterine appendages, it is necessary to cut through a very thick abdominal wall. This condition necessitates a relatively larger incision than is required where there is less fat and the parietes have been atrophied by pressure from within.

[*To be continued.*]

Clinical Reviews.

LE LAIT ET LE RÉGIME LACTÉ—PAR GASTON MALAPERT DU PEUX, Docteur en Médecine etc. Paris.—J. B. Bailliere et Fils 1891.

MILK AND THE MILK DIET. By DR. DU PEUX, ETC.

That milk is the most precious of all the nutritive substances furnished by nature, a providential aliment; that it is of the greatest service at different times and ages, as well in health as in disease; that it serves alike as food, as medicine, and as a vehicle for both; and that it is indispensible for the physician who would prescribe it intelligently to know its nature, its chemical composition, its peculiarities, its varieties and its counterfeits, are the propositions which are carefully discussed in the first hundred pages of this creamy little book.

Of the possible transmission of diseases by milk the author says: "Concerning tuberculosis, it is not enough to examine only the women who are employed as wet-nurses; we must look carefully to the health of the animals from whom the milk is taken. For it appears that phthisis is a frequent disease among cows that live in the stables of our large cities, where they are deprived of air and submitted to a diet that forces them to yield a large quantity of milk. * * * *

"The raw milk from cows with phthisis is suspicious and may transmit the disease, especially when there is a tuberculous alteration in the mammary glands. But if the tuberculous milk is boiled it is harmless. Of all the animals whose milk we eat or drink the cow is the most apt to be tuberculous; and even those that look the best are not always the most healthy. The milk of the mare, the ass and the goat are much less likely to be mischievous, for these animals are only exceptionally tuberculous.

"As for the transmission of syphilis by milk, the question is still an open one; Prof. Tarnier reports a case which argues against it, while Prof. Fournier believes in it."

To the sterilization of milk by heat a very interesting chapter is given. It should be practiced directly the milk is drawn. "The troubles that result from using infected

milk are twofold; they not only concern the parasites themselves, but also the toxical products which they yield. Doubtless a temperature of from 180 to 200° F. might remove the first source of danger, but as to the second it would be almost wholly powerless. If we wait a long time after the milk has been drawn and the temperature is favorable, the germs that are always present in the milk develop rapidly; and not only do they multiply exuberantly but, because of their biological activity they secrete such toxical products as resemble those which appear under their influence in the intestine of the new-born child."

Part II. is devoted to the milk diet, in its modified and its exclusive forms, as an adjuvant to the proper medical treatment of various forms of disease. The recommendations are based upon Debove's three principal indications for its employment: (1) As an aliment that is of easy digestion: (2) as a modifier of nutrition; and (3) as a diuretic. These practical rules, upon which some of us have prescribed this diet for years without ever having seen them in print, are applied by the author in the most sensible way. First, however, we have some hints that are worth remembering:

"In the exclusive milk diet (which he insists should not be adopted or relinquished suddenly) the patient should take no other aliment or drinks, for, as we have already shown, it alone is sufficient. The doctor may often be told by his patients that they cannot live upon it, and on this point he may have to overcome their prejudices. The total quantity required will vary materially, much depending upon the age of the patient, the nature and period of development of the disease, the effect desired, etc. From four to six pints is the daily quantity for chronic cases. But if this quantity seems very large to the patient, the doctor must be careful not to tell him to drink only as much as he pleases and at such times as he chooses.

"This would be a serious error, for we are persuaded that the good results of this diet can only be obtained by specifically insisting upon the quantity that shall be taken, as well as the time of taking it. Otherwise this diet will be repulsive, and it may give rise to indigestion and to dilatation of the stomach. It is the manner in which one takes the milk that furnishes the secret of success, especially in gastric affections.

"The proper method is very simple but it is seldom employed. It consists in taking the milk in small quantities,

say a swallow at a time, and at short and regular intervals, as for example every five minutes. This reduces the labor of the stomach to its minimum, avoids surcharging it with liquid, does not drown it, or cause a painful distention, all of which conditions should be prevented."

The quantity for the twenty-four hours may be so divided as to constitute four meals, that are to be taken at regular times and in the deliberate manner just described. The experiments of Richet prove that milk remains but a short time in the stomach, for at the end of an hour only slight traces of it could be found.

For those persons who cannot overcome their repugnance to milk the author advises to add a little brandy, kirsch, an infusion of black tea, or of violets to mask its peculiar taste. The allowance of a mixed diet is sometimes permissible. The constipation that may be caused by this diet is easily remedied. If a diarrhœa results it is a sign that the milk disagrees.

"We should state however, that milk constitutes a diet that *is* insufficient for those who wish to continue their usual labor. In this case the waste exceeds repair, and the subject loses flesh. His strength being reduced it is natural to conclude that he cannot do as much work under this aliment as when he is taking his usual diet. If you consult those who have taken the milk diet exclusively you will find that they complain of the above symptoms.

"Therefore milk constitutes a diet that will sustain life, but it alone is not sufficient to repair the losses of an organism that is already weakened by disease and which is still further weakened by continued labor. The doctor should be aware of this fact, so that he may assure his patients who are afraid of dying of hunger that they must limit their exercise to so much only as is necessary for their health."

Chapter II. of this section treats of the mother's milk and of the miserable counterfeits of it for babies. Chapter III. states the claims of milk as a diet in diseases of every portion of the digestive tube, in phthisis, chlorosis, obesity, diabetes, anasarca, nephritis, the albuminuria of pregnancy, in pleurisy, in cardiac affections, uræmia, in malignant jaundice, in gout and in metritis. The book ends with a very interesting chapter on milk as suited to old age, on the *petit-lait* cure, and on milk as a diuretic.

THE BIOGRAPHY OF EPHRAIM M'DOWELL, M. D., "The Father of Ovariotomy," by His Granddaughter, MARY YOUNG RIDENBAUGH. Together with valuable scientific treatises and articles relating to Ovariotomy and eulogistic letters from Eminent Members of the Medical Profession in Europe and America. New York: Charles L. Webster and Company, 1890.; 8vo, pp. 558.

Whoever has been in any way interested or benefited by what has come down to us from the "Father of Ovariotomy," will enjoy the reading of this book It consists of sixteen chapters that have either been written or edited by the accomplished granddaughter of Dr. Ephraim McDowell. Their titles include an Introduction; the Ancestral Line; his Early Life and Educational Advantages; Return from Edinburgh; the First case of Ovariotomy; Persecutions; Death; Criticisms and Comments; Comments upon Ovariotomy; Biographical Sketch, by the late Dr. John D. Jackson; Sketch by Dr. W. W. Dawson; Essays by Drs. J. H. McIntyre and N. Bozeman; Eulogistic Letters, and the Memorial Services at the unveiling of the McDowell Monument, at Danville, Ky., May 14, 1879. The work is prefaced by a very satisfactory portrait of its subject, and is printed and bound in excellent style. There are also three other cuts: the old McDowell residence; a full page illustration of the first ovariotomy, with the patient lying upon the table and everything ready for work, the quaint dress, surroundings and furniture of the apartment being primitive enough; and a beautiful picture of the aforesaid monument.

There are a thousand curious and interesting things in this book. Dr. Ephraim McDowell was the ninth, not the seventh son; he made his first ovariotomy in 1809, nine years before taking his degree; he went to Europe three times to perform the Cæsarean section, saving both the mother and child in the first two cases. He operated successfully for stone and also for hernia upon one of the Presidents of the United States, and had another for his first assistant in an ovariotomy. He taught surgery in the medical department of the Transylvania University for a quarter of a century, during which time he stood "facile princeps" in surgery west of the Alleghenies. He did his work without anæsthetics, antiseptics or any of the modern appliances and safeguards; and he drew upon himself the full measure of criticsm and of persecution, but "answered never a word" that was unkind or unfair.

Sixty years have passed since the death of this remarkable man, and clinically speaking his wise, practical and prophetic mission has accomplished more, directly and indirectly, for the relief of human suffering and the saving of human life than has been done by any other surgeon of ancient or modern times. To have gathered all that concerns the history of his life and labors, and especially of the operation that will always and everywhere be associated with his name, into a single volume, is an undertaking that was worthy of the best talent of his gifted granddaughter. The only blot on the escutcheon is the chapter devoted to the "crank" nephew, much of whose personal history should have been dumped into oblivion.

NEW BOOKS AND NEW PUBLICATIONS RECEIVED.—Transactions of the Forty-third session of the American Institute of Homœpathy (Forty-seventh Anniversary), held at Waukesha, Wis., June 16-20, 1890. Edited by the General Secretary, Pemberton Dudley, M. D., Philadelphia, 1890, pp. 857.——Ointments and Oleates, especially in Diseases of the Skin, by John V. Shoemaker, A. M., M. D., Prof. etc.; Second Edition: Philadelphia and London, F. A. Davis, publisher, 1890.——The After-treatment of Laparotomy, by T. J. Watkins, M. D., Chicago.——Quiz-Compends No. 9, A Compend of Surgery for Students and Physicians, by Orville Horwitz, B. S., M. D., etc., etc.; Third Edition, Philadelphia: P. Blakeston, Son & Co.——Electricity *vs.* the Knife in the treatment of Pelvic Disease, by W. B. Sprague, M. D., Detroit.——"What Ails the Baby?" by John Dewar, M. D., The "Red Cross" Series: Brentano, pp. 96.——Traité de Gynécologie clinique et opératoire, par S. Pozzi, Professeur, etc., etc., etc., avec 451 figures dans le texte. Paris: G. Masson, Editeur, 1890, pp. 1156.

IN MEMORIAM.

Brief notice was given in our last issue of the death of our lamented colleague, Prof. William S. Gee. Dr. Gee was born in Clinton, Missouri, August 6, 1856. He matriculated in the Hahnemann Medical College and Hospital of this city in the autumn of 1879, and took its degree in the spring of 1881. He was a faithful and diligent student, and after graduating, passed a competitive examination for the post of house surgeon in the Hahnemann Hospital, the duties of which he performed most acceptably for one year. Soon after that he began practice in Hyde Park, where he built up an excellent and even an extraordinary reputation, and where he remained until his death. In 1885 he became a co-professor of Materia Medica and Therapeutics in his *alma mater* in which capacity he soon became very popular and useful.

Dr. Gee was an ardent and enthusiastic homœopathist. He loved especially to study, to discourse upon, and to apply its philosophy to the cure of disease. He had a remarkable gift in making his subject interesting, and in infusing his own zealous spirit into the minds of the members of the large classes that came to hear him. Had his life been spared there is little doubt that he would soon have taken superior rank as a teacher and a representative of his own particular branch of medical study. His death is a great loss to the college and to all who are in any way connected with it.

Prof. Gee was taken ill with hemoptysis in the spring of 1890, at the close of the winter term in our college. This hemorrhage recurred and his health failed so rapidly that, despite a several months' residence in Colorado, he continued to decline with pulmonary phthisis, and finally passed away on the evening of November 11, at his home and among his weeping friends. He left a most excellent wife and two lovely children.

The funeral services were conducted in the Hyde Park Presbyterian church of which he was a devout member, and were attended by the Faculty and the students of the Hahnemann Medical College, and a large congregation of his former patients and friends.

On the following Sunday afternoon, Nov. 16, a Memorial Service was held in the hospital amphitheatre. The

platform was occupied by the Faculty and the body of the room by a large gathering of medical students who had come thither to pay their last tribute to their departed friend. The President of the Institution, Dr. D. S. Smith, occupied the chair. The services were opened with prayer by Prof. Leavitt. The following resolutions were then presented and pending their adoption brief and touching addresses were made by Professors Hall, Crawford, Arnulphy, Halbert, Ludlam and Smith.

WHEREAS: In the order of Providence we have been sorely afflicted by the illness and death of our colleague, Professor and friend, DR. WILLIAM S. GEE, and are therefore met in mutual condolence, be it

Resolved, That in every regard, and in all the relations that we have sustained with Dr. Gee we have found him to be earnest, honest, sincere and capable.

Resolved, That we shall always remember and cherish his friendship and kindly feeling, his interest in our work and welfare, and shall take his example as worthy of imitation in our professional capacity and in our future studies.

Resolved, That we hereby tender our warmest sympathy to his esteemed widow, and to all the members of his afflicted family and that we request the publication of these resolutions in the CLINIQUE and the medical press.

A special meeting of the College Class for the session of '90-'91, was also held, at which the following preamble and resolutions were unamimously adopted:

WHEREAS: It has seemed good to Almighty God to remove our late worthy and highly esteemed PROFESSOR W. S. GEE, and

WHEREAS, The intimate relations held by the deceased with the students of this college render it proper that we should place upon record our appreciation of his services as an instructor and of his merits as a man, therefore

Resolved, That we deplore his death with deep feelings of regret which are softened only by the hope that his spirit is with those who, having fought the good fight here, are enjoying perfect happiness in a better world.

Resolved, That we extend to his afflicted relatives our sincere condolence and our earnest sympathy in their affliction at the loss of one who was a good citizen, a thorough physician and an upright man.

Resolved, That the students of this college attend the obsequies of our deceased professor in a body, and that the college be hung with the emblems of mourning until the funeral ceremony shall have been performed.

Resolved, That a copy of the foregoing resolutions, signed by the committee, be tendered the relatives of the deceased.

Committee { H. A. NOYES,
MRS. HATTIE BIGGER,
G. H. RIPLEY,
BEATRICE CHURCHILL,
H. J. MACOMBER.

Miscellaneous Items.

The compliments of the season to our friends and subscribers.—The Mass. Hom. Med. Society will hold its semi-centenial aniversary at the Hotel Vendome in Boston Dec. 23, its committee having issued a circular from which we extract the following :—"When we consider that within a few years the State has established a homœopathic insanc hospital at Westborough, which contains over five hundred patients; that it has in the last year given $120,000 for the enlargement of our Massachusetts Homœopathic Hospital; that a single legacy has this year been given exceeding in amount $150,000, and which will be used for the support of the hospital; that the city has contributed a large site of land on which to erect a Homœopathic Dispensary, and that generous donations have been given therefor; that five hospitals have been established in various cities in the State, in which both homœopathic and allopathic treatment are equally provided; that a medical school has been established in connection with the Boston University which has proved very successful and added large numbers of well-educated physicians to our ranks; we have many causes for gratitude and rejoicing." *Selah.*—The *Monthly Hom. Review*, of London, for Dec. copies, with credit, a large share of Prof. Laning's lectures in the *Clinique* on Diabetes.—Death has robbed us of another old friend in the person of Dr. C. M. Dinsmoor, of Omaha, who died Dec. 8, of diabetes complicated with a large carbuncle located in the sacral region.—The course on Medical Jurisprudence now being given by Robert H. McMurty, Esq., in the old Hahnemann is a great success.—Prof. Crawford's lecture in this issue is in evidence that he is coming to the front again after his prolonged illness.—We have it on good authority that the Eye and Ear clinic in the Hahnemann is the biggest and the best in the city.—Dr. Hoyne's report as treasurer for the hospital contained in our Nov. No., has brought us a bag-full of congratulations.—Dr. C. S. Penfield, '80, of Spokane Falls, has delighted his friends in this city and vicinity with a brief visit.—Prof. Shears will present the report on Surgery at the next meeting of the Clinical Society, Dec. 27.—This year and we say it before the Commencement Day, the

present class of students is the best in the history of the College.—One hundred and thirty-six second and third course, and about an equal number of junior students are in attendance at the old Hahnemann.—The World's Directory of Homœopathic Physicians and Reference Hand Book will be published early in January, 1891. Besides containing the names of physicians in the U. S., all those of the foreign countries will be published, together with a full list of Colleges, Medical Societies and Publications. Dr. H. A. Mumaw, of Detroit, Mich., is the enterprising editor.—The holiday vacation lasts for a week only, beginning Wednesday Evening, December 24, the lectures being resumed Friday, January 2, 1891.—This year the Annual Alumni Banquet will be held in the new grand Banquet Hall of the Auditorium, Thursday Evening, March 19, 1891. —A new time-table of lectures will be soon issued for the second half of the term. The Alumni are supplied on application.—To keep looking neat while we stay, the management have recently painted the outside of the old Hospital.

VALEDICTORY.—In closing Vol. XI of the CLINIQUE, we return sincere thanks to all the home and widely-scattered friends who have helped to make it so very successful and useful. Its enlargement one year ago was an experiment, but it is so no longer, and it is now evident, by the most practical test, that the profession is ready to support a periodical that is neither seasoned nor stuffed with controversy.

During the year past this journal has furnished its readers with *twenty-one* clinical lectures; *eleven* clinical reports that were presented to the Clinical Society, with the discussions that followed; *sixty-eight* volunteer papers on practical subjects connected with Medicine, Surgery, Gynecology and Obstetrics, and more than *one hundred* clinical cases, besides clinical reviews, items, etc., and *thirty* illustrations, nearly all of which were new and original.

The CLINIQUE will be issued regularly at the old date and rate and in the same form, and, it is enough to say, will not fall behind its old reputation in the year to come.

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